Chapter 6: Operationalizing the Plan

In order to understand how to operationalize the plan, it is essential to remember the developmental stages of reform. SFY 01/02 (State Fiscal Year July 1, 2001-June 30, 2002) was a time for establishing an understanding of the foundation of reform. SFY 02/03 was an opportunity for clarifications and adjustments regarding design elements and expectations of reform. SFY03/04 will involve the completion of operational detail with extensive attention to system transition. SFY 04/05 and beyond will involve comprehensive implementation and continued strategic evolution.

Following the developmental process summarized above, this Chapter provides an overview of the efforts to operationalize the state plan. The process of moving the system forward is best described over a three-year period, as follows:

- **SFY 02/03 Outcomes:** (1) Completion of critical reform related organizing principles and corresponding design expectations, and (2) development of the essential structure to support reform.

- **SFY 03/04 Intended Outcome:** (1) Transitioning the design and structure through discrete operational developments.

- **SFY 04/05 Intended Outcome:** (1) Initiating the evolution of the system in order to fulfill the vision and mission of reform.

Clear direction and policy was needed before the concepts and principles of reform could be put into detail for the operations at the state and local level to be supported as well as understood by the various stakeholders such as the area programs, county programs, families/consumers and providers. SFY 02-03 served as the year to clarify those concepts. Some of the major areas included: the development and submission of the local business plan; the development of the cost modeling for a local management entity (LME); the flow of the uniform portal and access system; the release of the revised service definitions, including provider qualifications and utilization management guidelines; identification of target populations and non target populations; implementation of the Integrated Payment and Reporting System (IPRS); expansion of community capacity as associated with the Olmstead decision and state facility downsizing; and providing training and education regarding the intent of reform.

These developments contribute to the next stage of reform. The upcoming year will concentrate on phasing in the implementation of those decisions. As we move forward with the operations of reform, the major areas of focus for SFY 03/04 include target and non-target populations, assessing community and state systems serving target and non-target populations, and overall financing strategies for the system including local management entities and services to consumers and their families. Attention will also be given to assisting LMEs in the development of provider networks. Within each area, there are many details that must be established and communicated,

business or clinical practices changed and rules amended, all while assuring that the actions taken by the stakeholders are within the parameters of system reform and their local approved business plan. Although not included in this document, the Division of MH/DD/SAS will maintain and publish an operations plan regarding the steps being taken to implement the details of reform. This list will be posted on the DMH/DD/SA web page and periodically updated regarding the status of the plan and will include revisions and products completed.

On September 27, 2002, a Director's Communication Bulletin series was established to provide a single point for distributing key developments regarding reform. Communications were distributed addressing the issues of target populations, housing, local business plans, key questions and answers, community hospitals and adult mental health best practices. They were distributed to a wide audience of consumer and family organizations, area/county programs, county commissioners and managers, various stakeholders, and the provider community. The communications are posted on the Division's web page as well. This process will continue to be used to update any developments of reform after the publication of this plan (State Plan 2003). As the decisions are reached, products produced and implementation steps are prepared as outlined in the subsequent section of this chapter, this communication series along with the Medicaid Bulletin and the Division of MH/DD/SAS web page will be used to distribute and communicate the information.

It is noted that there are considerations of greater flexibility included in this chapter. This flexibility is intended to support community transitional needs. These flexibilities are not intended to negate or stand in the way of community systems that have been pursuing reform in an appropriate and aggressive manner. These flexibilities are intended to address the needs of communities who have been making great efforts to earnestly support and appropriately pursue reform efforts and have encountered legitimate barriers or circumstances that have contributed to a slower pace of development. However, these flexibilities are not intended to create opportunities for stalling or stopping reform efforts within systems that have not earnestly embraced the difficult challenges of change that will result in a better system for North Carolina.

The major areas of operationalization that will be addressed in this chapter include the following:

Citizens We Support and Serve

- *Target and Non-Target Populations*

Supporting and Serving our Citizens

- *Clinical Supports and Services*
- *Administrative Supports and Services*

State and Community Systems Working Together

- *Partnering with Consumers and Families*
- *State - Local Public Partnership*
- *Public - Private Partnership*

In this chapter, there are several major products that will be delivered during SFY 03/04. The development, implementation and management of these products are included in the discrete and detailed operations plan, which is available on the Division web site at: http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.html.

A summary of the major products to be delivered, by SFY 03/04 quarters, are as follows:

SFY 03/04 1st Quarter (July 1, 2003 through September 30, 2003)

- LME Cost Model Implementation Plan.
- County Maintenance of Effort (MOE) Guidelines.
- Rollout of New Supports and Services Plan. (Note: This plan will include proposed supports and services, provider qualifications and rates pending federal and state related approvals.)
- Children's Services Plan.
- Comprehensive Training and Education Plan (new supports and services related).
- Comprehensive Provider Network Guidelines.
- Updated overview of area/county program fiscal settlement for SFY 04 based on changes included in the updated State Plan.

SFY 03/04 3rd Quarter (January 1, 2004 through March 31, 2004)

- Completion of negotiated Division/LME performance-based contracts for SFY 04/05.
- Plan to address inequities in community funding.
- Long-term finance strategy.

Each of the products identified above in SFY03-04 will include comprehensive and discrete detail, supporting products and conditions necessary to operationalize the plan, clear action steps, timelines and a process for product management. In reviewing the summary list above and reading through this chapter, the reader should consider the following:

- The products to be delivered are ordered by quarter. This reflects the necessary sequence. The order within each quarter is not sequenced.

- A great deal of work has been completed for all of the products identified for the first quarter of SFY 03/04. These work efforts include consideration of work products provided by the SFY 01/02 State plan work groups. Most of SFY 02/03 has involved coordinating all product development efforts into appropriately integrated comprehensive and complete products.

Managing the Challenges of Change: The Citizens We Support and Serve

- **SFY 02/03 Outcomes:** (1) Established target populations, (2) Initiated community transition to support and serve the target population, (3) Evaluated non-target populations to determine if any adjustments were needed, and (4) Continued state facility downsizing activities with a concurrent development of additional community capacity through the transfer of resources from state facilities to community programs and the utilization of the MH/DD/SA Trust Fund.

- **SFY 03/04 Intended Outcomes:** (1) Complete any adjustments to the target populations based on Area Program learning during the transition to the target populations, (2) Continue transition to target populations, and (3) Provide technical assistance around natural and community supports for non-target individuals.

- **SFY 04/05 Intended Outcomes:** (1) Support and serve the target populations, and (2) Continue evaluation of the target populations to determine necessary adjustments.

Target and Non-Target Populations

In SFY 02-03, the following communications were distributed regarding target populations and non-target populations.

- Memorandum to Area Directors, Area Board Chairs and County Managers dated September 13, 2002, regarding "Service Transition for Individuals Not Included in MH State Plan Target Populations." This memorandum outlined the process for area programs to evaluate their current caseloads to determine who met or did not meet the target population criteria and the process by which the area programs would continue to get paid for serving the non-target population during the fiscal year. This process included the clarification of cash flow while implementing the Integrated Payment and Reporting System (IPRS) and financial year-end settlement procedures.
- State Plan Communication Bulletin #003, dated October 28, 2002, regarding "Management of State Plan Target and Non-Target Populations." This document provided more direction regarding the establishment of resources to serve non-target populations while re-emphasizing the role of transition and area programs' ongoing responsibility to continue to serve consumers as they began to build alternative resources.

A key element in system reform is to ensure that individuals that fall outside of the target populations are appropriately assessed and effectively linked with alternate community resources to meet their needs. Reform efforts which seek to focus finite resources on individuals with the greatest need must not, and cannot, lose sight of the need to address transition and long term needs of individuals who will no longer be within the identified target populations. As described in Chapter 4, system reform provides the framework for the local system organization, including networks and services for target and non-target populations.

The period of July 1, 2002 through June 30, 2003 was initially designated as the period during which area/county programs identified individuals who would not fall within the target population groups as defined in the State Plan 2002 Chapter 3, Section – Target Populations. Transition planning began for all persons served in area/county programs and contract agencies, as well as beginning to identify strategies for engaging or identifying those people who should be in the system or meet target population. As stated in communications, it was critical that "individuals not be discharged or transitioned to other services and supports without careful planning, therefore, individuals within the non-target populations will be assisted in moving to other alternatives within the community over a reasonable period of time." During last year, the Division, in conjunction with area/county programs, collected data from area/county programs related to individuals falling outside of the target populations. During April and May 2003, the Division assessed the information collected in SFY 02-03 to determine if changes were needed in the target populations. Chapter 2 includes modifications to last year's published target population criteria based upon review of the data collected from the area programs for SFY 02-03.

In order to address the specific issues related to individual community network and resource capacity and the scope of those individuals who have been identified as non-target population, the Division will work with each LME regarding the transition. This process will include an extension of authorization to expend Division funds to serve non-target populations to June 30, 2004, while the Division works with LMEs to ensure full transition of non-target populations by no later than June 30, 2004. It is not the intent of the transition for LMEs or providers to continue to provide services to consumers and families as a means to avoid the transition to target population or to avoid the development of alternative network sources and resources. Rather, it is recognition of the diversity of the communities in terms of available community resources and the need to ensure that individuals not included in target populations transition to alternate community services and supports in a safe and planned manner.

The transition process for serving target and non-target populations has included completing consumer assessments to determine whether individuals qualified for target or non-target populations. Through this process, the type of care and level of care needed by individuals was identified. In this process, and in the future assessments, it will be essential to determine if individuals are being served with best practices and at the appropriate levels and to ensure that person-centered planning will continue to shape service delivery. If the current type of service is not best practice, or if the service level either exceeds or falls short of that indicated for the individuals, then the need for the type of service and/or the level of care must be realigned. This process will help assure the optimal use of resources for individuals who are most in need of services, while addressing the needs of individuals in the non-target populations. As a function of the LME, service coordination should not only address individual consumers but also should assist with the development of service and support capacity for non-target population. This includes demonstrating a system that is responsive to those individuals who show signs of deterioration or who need an elevated level of care.

In future years continued community management by the LMEs as well as the Division will allow adjustments to the target populations based on sound empirical evidence of need and public policy expectations.

Managing the Challenges of Change: Supporting and Serving our Citizens

Clinical Supports and Services

- **SFY 02/03 Outcomes:** (1) Developed fundamental expectations of support and service best practice, (2) Developed state guidance regarding hospital downsizing and concomitant flow of funds to support community capacity, and (3) Developed a plan for technical support for communities in transitioning DD Olmstead clients.

- **SFY 03/04 Intended Outcomes:** (1) Distribute approved service definitions with accompanying provider qualifications and utilization management guidelines, (2) Submit a newly revised Medicaid State Plan in keeping with best practice, (3) Set a timeline and provide training and information for systems to transition to new support and service expectations, (4) Initiate transition to new service expectations, (5) Develop outcome and performance based contracts for LMEs for SFY 04/05, (6) Track Olmstead efforts and continue to offer technical assistance for these high priority populations, (7) Update changes in target populations as appropriate, and (8) Prepare an outline for a plan that will expand the evidence-based substance abuse prevention initiative to include mental health and developmental disabilities.

- **SFY 04/05 Intended Outcomes:** (1) Continue quality improvement efforts to assure model fidelity of the supports and services, (2) Continue research, dissemination and implementation of new best practices, and (3) Develop incentive based contracting for LMEs in meeting goals related to best practice.

Changes in the service definitions reflect models of practice that are going to be purchased, as well as the manner by which providers must be qualified and organized in order to participate within the public system. This includes expectations that providers will not "pick and choose" whom they support and serve in order to maximize profits or margins, as well as expectations that they are part of a larger community system and part of the LME provider network.

The best practice guidelines presented in Chapter 3 were developed in collaboration with selected expert stakeholders and consultants. In order to implement best practices, the goal is to develop a best practice based service taxonomy and to remove nonessential differences between Medicaid, Health Choice and Division funded services. To accomplish the goal, service definitions and the revised CAP-MR/DD Waiver will be completed in the first quarter of SFY 03/04. This rewrite of the definitions utilizes in a more comprehensive manner, the rehabilitation option under Medicaid, self-determination principles, Home and Community Based waivers (HCBW: CAP-MR/DD) that emphasize a person's integration into their community and in the settings that routine activities of life occur. This includes less focus on traditional office based interventions, more options besides out of home placements and the framework of person centeredness and family focus. As part of the definitions, preliminary utilization criteria and initial provider qualifications are identified and included. This includes the identification of the required standards for licensure for new services and modification of standards for existing services in order to be aligned with best practice

expectations. Upon completion of the review for service definitions, the State Medicaid Plan, the CAP-MR/DD Waiver and state funding definitions will be revised for implementation July 1, 2004. As part of the process, the Division, in conjunction with the Division of Medical Assistance, will publish in the first quarter of FY 03-04 an implementation plan that outlines timelines for actions required for successful implementation, including but not limited to federal approvals, rule revisions and transition planning for systems managers, providers and consumers.

Although the guidelines referenced above and in Chapter 3 include child mental health services, additional work is required to ensure that child mental health services are consistent with North Carolina's mental health reform effort. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services has engaged in developing a comprehensive child mental health plan. The purpose of this plan is to develop a framework in order to improve structural, financing, and organizational issues encountered in serving children with mental health disorders and their families. The plan will address services for all children who receive publicly funded mental health services, including those who are in residence at state facilities and those who are served in the community. It is anticipated that the comprehensive child mental health plan will foster an increase in the utilization of community-based services, informal services and supports. Consequently, it is anticipated that the plan will permit a decrease in unnecessary placement in residential facilities and state psychiatric hospitals.

To assist in this planning process, the Division is working closely with community stakeholders through the State Collaborative for Children's Services. Many members of the State Collaborative are serving on the 35 member advisory group for the plan which includes representatives from juvenile justice, social services, public health, public instruction, area mental health programs, child residential facilities, state psychiatric hospitals, universities, advocacy groups and parents of children with serious emotional disturbance.

Future planning efforts will focus on the development of specific action steps, outcome measures, accountability and public feedback mechanisms. The target date for completion of this plan is the first quarter of SFY 03/04.

With the publication of the best practice guides and the modifications of the service definitions, one of the first focuses of change is the recognition of the training and education needed at every level in order to prepare providers and their staff, families and consumers and other stakeholders. This includes not only formal educational opportunities but also an ownership of on-going relationships and processes that reduce stigma, promote cultural proficiency and develop a competent workforce. In order to facilitate this change, a comprehensive training and education plan will be developed by the first quarter of SFY 03/04. This plan will build upon the competencies established during the last year and expand to the newly identified services including case management. In addition, the plan will include the identification and development of resources at the pre-service, in-service and formal professional training at all levels of the state's educational system. Universities, community colleges and area health education centers (AHECs) are valuable partners in the retraining and future training of the professional and paraprofessional staff in the system.

As part of the local business plan development, area/county programs have assessed the availability of providers. As expected, availability of providers varies within the catchment areas as well as in the scope and diversity of providers. Each local business plan identified strategies or goals for building a qualified provider network and ancillary efforts necessary to support the gaps identified. The development of a qualified provider network is critical for successful implementation of reform and to honor the foundations of consumer choice. In order to promote such development providers must have clear expectation regarding the practices expected and standards required. These standards will be outlined in the service definitions and the rules.

The Division of MH/DD/SAS, in conjunction with the Division of Medical Assistance and the Controller's Office will establish the parameters for the provider network including network composition, rate setting requirements, enrollment procedures and procurement procedures. This includes the process for rule making by both the Commission of MH/DD/SAS, the Division of Medical Assistance and by the Secretary. This information will be distributed within the first quarter of SFY 03-04.

The Division is responsible for management of state-operated services and facilities and is held to the same quality and best practice standards, as are local management entities in overseeing service delivery. This is a very unique aspect of the Division in that it holds a dual manager/provider role and responsibility. The State Operated Services section of the Division as a provider of services, is part of the community as a resource to the LMEs and the constituents they serve. The state-operated services are actually part of the LMEs provider network. The state local relationship is particularly important with regard to clients' transitioning from state-operated facilities into a community-based system of supports and services. Clients will have in place, prior to transition, person-centered plans that adequately address their array of needs and that are approved by the state and local systems.

The state's facilities of DMH/DD/SAS must be committed to best practices and must ensure exemplary management in the operation of the facilities. They must also be partners, leaders and trainers in the transition of state operations to community capacity developments. In order to achieve the expansion of services in the community, the state facilities' expertise will be made available to the LMEs, especially for persons in the community who are in need of specialized services. The state-operated facilities will respond appropriately to the transition of residents from the institution to other supports and services in the community. Necessary appropriate technical assistance will be provided to the community service providers and families of these transitioned residents so those individuals may successfully acclimate to their new services and surroundings.

Concurrent with finance changes at the community level, the Division is continuing with state facility downsizing efforts and the transfer of institution-based resources to the community. As planned downsizing activities are initiated, Mental Health Trust Fund resources are utilized to provide bridge or transition funding for community capacity development, with ongoing operational resources transferred from institutions to the community as downsizing actually occurs.

In order to implement the above, beginning July 1, 2003 utilization of the four state psychiatric hospitals will be determined based upon a Division approved bed day allocation plan. Through this plan, bed days will be allocated to each LME in the following categories: Adult Admissions, Adult

Long-term, Geriatric Admissions, and Adolescent Admissions. Each LMEs initial bed day allocation will be based on its historical utilization, i.e. state fiscal years 00/02, of the subject beds.

During the five-year period of SFY 03/04 through 07/08, the number of bed days available for allocation will be reduced as the number of beds in the hospitals are reduced. The reduction in the number of hospital beds will be facilitated by the transfer of funds from the hospitals to the LMEs. As the funds are transferred to the LMEs and hospitals are downsized, the bed day allocation will move from one based on historical utilization to one based on the per capita population of the LME.

While access to the hospitals will continue to be governed by the current rules outlined in Admission and Discharge of Patients to State Psychiatric Hospitals, the Division will develop the necessary processes to implement the bed day allocation plan and modify the rules accordingly. Other rule modifications may include those necessary to enhance the relationship between the state facilities and the LME, in such areas of uniform portal and best practices.

As part of the unbroken chain of accountability, decisions regarding certification and accreditation that affect LMEs and providers (both agency based as well as independent practitioners) will be communicated within the first quarter of SFY 03-04. In addition, the LME will be responsible for implementing the monitoring required under SB 163, effective July 1, 2003. In a phase-in process of implementation, monitoring protocols will be developed with accompanying training and monitoring plans will be developed at the local levels between the providers and the LME.

Administrative Services and Support

- **SFY 02/03 Outcomes:** (1) Reviewed and provided guidance on the local business plan submissions, (2) Continued development of the funding formula and plan for the administrative functions of the service delivery system, (3) Determined LME administrative functions, and (4) Provided public policy guidance on the roles and functions of the LME—specifically related to divestiture of services and developing community capacity.

- **SFY 03-04 Intended Outcomes:** (1) Develop funding formula and plan for the service system, (2) Develop rates for services, (3) Develop plan for cost settlement for SFY 03/04, (4) Determine and provide training for the LME in how the funding plan will be implemented. (5) Continue to provide technical assistance in building community capacity for service and service divestiture, (6) Move to aggregate funding for CAP MR/DD services, (7) Finalize development of a long-term finance strategy, (8) Complete the LBP certification process for all systems approved as LMEs—including the approval of continued service provision per the state guidelines, (9) Develop the performance contract for SFY 04-05 —including incentives for exemplary service networks and service providers, and (10) LME cost model implementation plan.

- **SFY 04-05 Intended Outcomes:** (1) Fund the LME for administrative functions using new formula and plan, (2) Continue technical assistance and consultation regarding the functions of the LMEs, and (3) Implement relevant components of the long-term finance strategy.

Using the *State Plan 2002, Local Business Plan*, Section 5, area programs submitted local business plans to the Division by April 1, 2003. As outlined in the Director's Communication Bulleting #002, October 2, 2003, "Local Business Plan Submission and LME Certification", protocol for area program quarterly reporting and for on site visits were established. All Phase I local business plans were reviewed and site visits occurred in May 2003. The review of Phase II local business plans began in June with site visits to be scheduled prior to November 2003. The review of Phase III local business plans will begin in July 2003 with site visits to be completed prior to May 2004.

The performance agreement (required annually for area program funding) was revised to include benchmarks from the local business plan implementation. Benchmarks unique for each approved local business plan were established through a negotiated process and incorporated into the Division/LME annual Performance Agreement. In the future, it is planned that the Division will enter into a Contract Performance Agreement in lieu of the current Memorandum of Agreement to reflect the business relationship with Local Management Entities. Contracts between the LME and the State will be negotiated by the end of the third quarter of SFY 03/04 for implementation July 1, 2004.

During the upcoming fiscal year Phase I and II area programs will begin the process of reconfiguring their systems to align with functions and responsibilities of a local management entity. Area programs have three years to implement the strategic plan. Phase III area programs will begin the process in July 2004.

At both the state and local levels, transition and change must happen in order to implement successfully an organized system to support and serve people with mental illness, developmental disabilities and/or addictive disorders. Organizations must change their identity from being stand alone agencies to integrated systems that must cross boundaries and roles in order to maximize resources – resources that occur in every community for every citizen and those specialty supports and services that meet the unique needs of people with mental illness, developmental disabilities and/or addictive disorders.

As an outgrowth of the financial planning and development efforts in SFY 02/03 undertaken jointly with the DHHS Controller's Office and DMA, the Division is exploring conversion of the financing of services from a cost-based model to one founded on accepted, standardized rates. The proposed process of developing the service rates will be through a cost modeling process. This involves examining rate structures from within our state as well as other states to determine rates that best reflect the public policy expectations of the services and providers. Such an approach must not only promote efficiency and consistency across the system but should also eliminate, or significantly reduce, the need for expensive cost finding and non-Medicaid cost settlement activities.

In conjunction with the service definition development, provider qualifications and network requirements must be in place to support the definitions, outline the scope of providers required by the local system, inform providers of their responsibilities and transition current service practices and billing. As a result of those decisions, licensure, rules and policy administered by the Division of Medical Assistance, Division of MH/DD/SAS, the Division of Facility Services, DHHS Controller's Office and other affected departments and divisions must also be modified to support the actual daily operation. The modifications will be published and a feedback period will be scheduled. Upon completion of that process and depending on the specific action required the rule/policy would be implemented in conjunction with the plan for the rollout of the new supports and services.

The Division has undertaken the task of modifying the financing mechanisms with assistance from consultants and partner agencies in the Department of Health and Human Services. Consultants have included the Technical Assistance Collaborative (TAC), Pareto Solutions, LC, and Heart of the Matter Consulting. A Departmental Financing Workgroup, chaired by the Secretary, with representation from the Division, DHHS, Division of Medical Assistance, and various other stakeholders, has overseen the financing work to date. We have also continued to develop the finance strategy described in State Plan 2002. This long-term finance strategy will be developed by the end of the third quarter of SFY 03/04.

The current community mental health, developmental disabilities and substance abuse system is financed primarily through unit cost rates that combine the cost of services and administration. In the reform environment, these cost elements must be separated. Also, to ensure the optimum use of limited public resources, it is proposed that financing be based upon standardized models rather than on the actual costs incurred by entities that may be performing at varying levels of efficiency.

The first element addressed in the refinancing work has been determining the appropriate level of funding for the activities of LMEs. A cost model was developed that identified the primary functions of a LME as defined in legislative and administrative planning documents. These primary functions are:

- General administration and governance.
- Business management and accounting.
- Information management analysis and reporting.
- Provider relations and support.
- Access line, screening, triage and referral.
- Service management.
- Consumer affairs and customer services.
- Quality improvement and outcomes evaluation.

With the primary functions identified, assumptions were made regarding the demand for services that LMEs would experience from citizens in their geographical area and the "best practices" that would be employed by LMEs to effectively fulfill their responsibilities. Using the experience

elsewhere in the country of similar organizations assigned responsibility for managing behavioral health services, a mathematical model was developed that yields a cost per citizen per month (PCPM) to effectively and efficiently deliver the primary LME functions.

In the spring of 2003 the Report on Modeling Costs for the Local Management Entity was disseminated to area programs. The model was designed to estimate the cost of operating a LME according to guidelines set out by the State. Though there are many different ways an area program may fulfill these functions, the responsibilities are those mandated by the State. The final LME cost model will be released in the first quarter of SFY 03/04. Specifications included in the final model will include the method that will be employed to negotiate the per citizen per month (PCPM) with each LME, the financing of the model and considerations for transitional adjustments of the model to meet the transitional needs of LMEs.

SFY 03/04will be a time of transition in financing. Area/county programs are in different stages of their conversion to LMEs. Some programs have made significant strides in their efforts to divest of services[7], others have made substantial progress is accomplishing mergers and consolidations to provide for more efficient LME governance. Some organizations may be in a position to implement one or more LME functions in July and others later in the fiscal year. By July 1, 2004, the Division anticipates that LMEs will be funded based upon the standardized model. During this interim SFY 03/04, funding will be adapted as necessary to meet developmental stages of LMEs.

Modifying the financing of the public mental health, developmental disabilities and substance abuse service system is a critical element in the ultimate success of the system reform effort. Appropriate financial incentives will assist reform to go more smoothly; conversely financial disincentives could inhibit reform efforts. The financing method and rates for the new services are intended to create the incentives to return effective and efficient outcomes for people with disabilities. Draft rates for services will be released with the definitions during the first quarter of SFY 03/04. The process of developing the service rates will be through a cost modeling process. This involves examining rate structures from within our state as well as other states to determine rates that best reflect the public policy expectations of the services and providers.

The use of resources needs to be both flexible while also meeting the intent of reform. This factor requires a comprehensive funding plan, not just service rates or LME rates, that outlines the use of the county MOE and third party benefits. This plan will be released by the end of the first quarter of SFY 03/04.

Another goal of system finance reform is to address current inequities in funding. For a variety of historical reasons, variations exist in the current utilization of State institution resources and in allocations of community funding sources. A goal of the Division, and also required in system reform, is to narrow the gap in funding inequity. Narrowing this gap will initiate in SFY 04/05 and will occur over a period of at least five years. This time frame is intended to allow sufficient

[7] The LME providing services and divestiture options are taken from State Plan 2002 and offered as appendix E.

transition for moving to a realistic range. The plan to address inequities in funding will be developed by the end of the third quarter of SFY 03/04.

The overall finance strategy is intended to ultimately arrive at a more unified funding strategy. This concept involves the integration of revenue sources into a single community system. Public policy management responsibilities of this community system would be the responsibility of the LME. Private providers who are part of the LME provider network would carry out public policy implementation.

The information contained in State Plan 2003 does reflect a change in an option offered to LMEs in State Plan 2002. State Plan 2002 stated that assessment and case management (and psychiatry) could be retained by the LME if it divested of all other services. The discussion of the design described in this communication has raised a great deal of concern regarding these issues.

At the time the State Plan 2002 was completed, there was a great deal of confusion regarding concepts and practices of case management and service management. This created a blended definition of these two very different practices that required additional time to sort out. As we furthered the discussion regarding these two practices, we clearly realized that the models of case management currently applied did not reflect models that are currently used in this field. Case management in North Carolina seemed to largely reflect an inefficient method of a substitute for a management structure. This included a number of activities that are not relevant to appropriate case management models but are relevant to a number of responsibilities that a systems management entity would assume (e.g. quality assurance and improvement, fiscal accountability, network related monitoring, general service system management). That is not to say that a case manager does not have a role in these areas (monitoring the implementation of a person-centered plan contributes to the overall quality improvement efforts, as an example).

The change described in State Plan 2003 is intended to clean up the boundary between what is the responsibility of a systems manager (LME) and what is related to the delivery of service (case management). The foundation for understanding the overall systems strategic design is evident in the best practice support and services description provided in Chapter 3 and the LME cost model.

The inclusion of assessment in the service side is related to both efficiency and practicality. Accredited provider agencies are required to perform the assessment function. In addition, the LME is interested in systems level management, which includes monitoring the quality of assessments. Concerns regarding providers completing assessments in a manner to promote the services they provide is mitigated by the LME authorization process. The provider qualifications for providers of the assessment and person centered planning services will be developed after the service definitions have been completed. The nature of the organization of the provider systems will be addressed in the best practice communications and reflected in the provider qualifications.

There has been discussion regarding the LMEs ability to retain the assessment and case management responsibilities. This has centered on the concept of building a "fire wall" between the management and provider responsibilities. Such a "fire wall" would include where these responsibilities are delegated within the organization and protocols that describe how these

responsibilities interact and address conflict. However, until these responsibilities are truly separated through two separate entities, the principle-agent [8]problem exists.

With clear definitions of case management and care management, we will find that conducting both the management function and the service function is fraught with complication and conflict. The goal is to clearly separate the management and service functions and to cease using the service function of case management as a replacement for underdeveloped management functions. By developing clear definitions between these two functions and allowing the local LMEs to evolve their systems locally, this goal can be achieved. During this transition, however, the state will establish clear guidelines and oversight to insure the LMEs are developing provider capacity to provide case management and that the principle agent conflict for case managers is not compromised.

One final concern regarding the case management issue is related to changes in expectations to communities who spent time in developing local business plans (LBPs). The state plan was marketed as a process that provided an opportunity for flexible community planning in the design of their system.

Local flexibility in systems design is critical, however it must relate to the need for fundamental expectations of all citizens of the state to be responded to in a common manner. For example, the state defines expectations for timelines in response to access across the state while the local community determines the best methods for them to achieve this expectation. This is also true for the population to be served and the types of services to be provided. The design of management responsibilities is determined by the state. If there were no consistency in these expectations, there would be no statewide consistent management system. The local system determines how to best meet these expectations. As stated in the preceding paragraphs, local flexibility in achieving these goals is needed and noted.

Managing the Challenges of Change: State and Community Systems Working Together

Partnering with Consumers and Families

- **SFY 02/03 Outcome:** (1) Initiated opportunities for people with disabilities and families to shape the reform developments, (2) Hired the advocacy chief and staffed section with primary and secondary consumers, and (3) Evaluated local business plans for meaningful involvement of consumers and families in local plan development.

- **SFY 03/04 Intended Outcome:** (1) Establish the State CFAC, and (2) Provide technical assistance for local programs to increase consumer and family participation.

[8] Role and responsibility conflict.

- **SFY 04/05 Intended Outcome:** Advance the opportunities for people with disabilities and their families to influence the full range of the system -- from policy leadership to more discrete operations.

Most important to this entire reform effort are the intended beneficiaries – people with disabilities, their families and communities. We must maintain earnest and heart desired efforts to promote opportunities for people with disabilities and their families to assume increasing command of the system. The partnership with people with disabilities and their families is essential to the many relationships that need to be continuously developed. This includes the policy relationship between the public partners – the state and local systems – as the parties ultimately accountable for the management of public policy. This also includes the public-private relationship necessary for the effective and efficient implementation of public policy. The development of these relationships also begin to more fully reflect the "unbroken chain of accountability" necessary for better appreciating roles and responsibilities.

During SFY 03/04 the Division will be supporting the development of the S-CFAC. The guidelines for the S-CFAC were developed in SFY 02/03 by a workgroup whose composition was primarily consumers. The delay in implementing the S-CFAC was related to the need to first re-organize the Division. The new organization is intended to promote the most conducive environment to advance the concept and practice of consumer command. The S-CFAC will be operational by the second quarter of SFY 03/04.

One of the key components of the Division re-organization is the Advocacy and Customer Services section. Like a number of states, it was originally planned to have a consumer ombudsman. However, given the desire to more comprehensively promote real meaningful consumer systems ownership, it was decided to create an entire section. Several key aspects of this section are as follows:

- **Selection of Chief:** The process of reviewing applications, selecting interviewees, conducting interviews, and making recommendations for candidates to the Secretary and Division Director involved a group of nine people-- six of whom were consumers. In addition, a consumer candidate was required for the position itself.
- **Executive Level Leadership:** The Chief of this section is a full and equal member of the Divisions Executive Leadership Team (ELT).
- **Executive Firewall:** Although the Chief of this section reports to the Division Director, he/she may take any matter at any time directly to the Secretary.
- **Systems Firewall:** The advocates of the state-operated facilities report under this section rather than to the state-operated facility Directors as they have done in the past.
- **Consumer Employees:** In hiring into a number of positions in this section, the Division is making efforts to employ consumers.

The Advocacy and Customer Services section continues its development. This is an exciting venture for the Division with the desire for the efforts of this section to greatly influence the

direction and operations of the Division. This section will also take the lead in pursuing the development of and providing the structural support for the S-CFAC.

The functional responsibilities of the LMEs offer an opportunity for consumers to become directly involved with the operations of the organization. These opportunities could be full or part time paid employment, application of various mechanisms of providing compensation in order to support individuals' participation or a simple voluntary arrangement. The following three functional responsibilities of the LME are intended to provide a brief presentation of examples of opportunities for more full consumer participation:

- **Provider Relations and Support:** Network development, orientation and training, monitoring.
- **Consumer Affairs and Customer Services**: Systems navigation, responding to customer inquiries and conducting consumer satisfaction interviews, as examples.
- **Quality Improvement and Outcomes Evaluation:** Full range participation in the systems CQI/TQM efforts.

During SFY 03/04, the Advocacy and Customer Services and the Community Policy Management sections of the Division will be developing direction, technical assistance and consultation to the field regarding opportunities for greater meaningful participation of consumers.

This document includes additional direction to the field regarding the local CFACs. This resulted from concerns that could be anticipated – the notion of consumer command is an evolving process. The Advocacy and Customer Services section will provide technical assistance and consultation to support the advancement of the local CFACs. In addition, this section will support the development of new grass roots community development of consumer advocacy groups.

State-Local Public Partnership

- **SFY 02/03 Outcome:** (1) Initiated a public policy relationship between the state and their local public partners.

- **SFY 03/04 Intended Outcome:** (1) Implement the public policy relationship between the state and their local public partners through the implementation of a formal venue for the development of the relationship, and (2) Provide a forum to discuss public policy issues.

- **SFY 04/05 Intended Outcome:** (1) Advance the public policy relationship between the state and their local public partners through on-going maturation of the relationship.

With the introduction of the *State Plan 2001: Blueprint for Change*, released in November 2001, a foundation for reform in North Carolina was created. With the publication of the State Plan 2002,

released in July 2002, three technical documents were included: the State Strategic Business Plan, the Local Business Plan and the Division's Reorganization Plan. These served as the platform from which the Division and area programs could begin the planning process to restructure through the development of strategic plans and Local Business Plans.

Within the Division's reorganization efforts, the Local Management Entity (LME) Systems Performance Team and other Teams were created and staffed to support the Division to meet the objectives set forth in the State Plan 2002: State Strategic Business Plan, Section III, and to support and assist all area programs with development and implementation of their local business plans. Staff was assigned to specific area programs to assist with efforts toward reform, regardless of the Phase selected for implementation. As staff who had previously been assigned to area programs began their new assignments these duties were transferred to members of the LME Systems Performance Team.

During SFY 02/03 there were formal county commissioner and county manager workshops held in regions across the state. Additionally, workshops and meetings were held with county commissioners, county managers, board members, area directors and stakeholders within specific programs. Communication Bulletin #005: Questions and Answers for County Commissioners/Managers was written as a direct result of questions raised at these meetings. By October 1, 2002 county authorities had submitted all letters of intent with choice of local governance, appointment of LME, and indication of phase-in preference.

Meetings were held in conjunction with the Council of Community Programs and the NC Association of County Commissioners for area program and county staff. Products were disseminated to assist area programs and counties in efforts to move forward. Two reports were disseminated by the Division to assist area programs in looking at prevalence, service need, penetration rates and Medicaid service billing.

During SFY 03/04 and evolving into the future, the Division will engage in a more formal public policy relationship with our county and LME partners. The public systems – state and county – are ultimately held accountable for the implantation and management of public policy.

Public-Private Partnership

Outlined in the foundation of reform is the role of consumers, families, advocates and providers. As we implement reform it is important that we promote and model public-private partnerships. This includes formalizing the process for meaningful input and review of stakeholders in a planned way. During SFY 02/03, the Division of MH/DD/SA formed an external stakeholder group to advise the Director regarding the implementation of reform. This group will be invited to continue serving in the role of the key stakeholder advisory group to provide guidance in the implementation of the reform efforts.

Within every local community, the relationship between the LME, the provider network and their community partners at large will be a vital component in successful implementation of reform.

LMEs are expected to cultivate partnerships among their community agencies such as law enforcement, juvenile justice, courts, social services, public school systems, community hospitals, and medical community in order to promote a comprehensive system of services and supports for people who have mh/dd/sa needs. As reviewed in the local business plan, concentrated efforts are needed to highlight the role of the LME with this community collaboration. Over the course of SFY 03/04, additional guidance will be provided regarding the desired outcome of successful partnerships.